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National Survey of Substance Abuse Treatment Services

The CBHSQ Report

Short Report

October 23, 2014*

SERVICES OFFERED BY OUTPATIENT-ONLY OPIOID TREATMENT PROGRAMS: 2012

AUTHORS

Alexander Strashny, Ph.D.

INTRODUCTION

National data indicate that opioid abuse—including both heroin and prescription drug (e.g., oxycodone or hydrocodone) abuse—continues to be a serious public health problem in the United States.[1] Trend data between 2002 and 2012 show that the number of persons meeting the criteria for heroin dependence or abuse in 2012 was more than double that in 2002 (467,000 vs. 214,000), and the number of persons with pain reliever dependence or abuse rose from 1.4 million to 2.1 million between 2004 and 2012.[1]

For those who are interested in quitting opiate use and entering treatment, withdrawal can be extremely uncomfortable, as it may include agitation, muscle aches, insomnia, abdominal cramping, diarrhea, and vomiting.[2] Depending on the opiate used and its half-life, withdrawal symptoms may begin within a few hours of last use and may take a week to several months to subside.[2] Craving for the drug may persist for years after drug cessation.[2] Because of these problems, relapse is common.

The risk of relapse can be reduced during detoxification and treatment when medication-assisted therapies are used to control the withdrawal symptoms.[3] The Food and Drug Administration (FDA) has approved three medications for the effective treatment of opioid addiction: methadone, buprenorphine (Suboxone® and Subutex®), and naltrexone. Methadone, in use since 1964 for opioid dependence, may be dispensed only in federally approved opioid treatment programs (OTPs).[3] Treatment protocols require that a client take the medication at the clinic where it is dispensed daily; take-home dosages are allowed only for clients who have been in treatment for a specified period of time and if other conditions are met.[3,4] However, buprenorphine may be prescribed by physicians who obtain specialized training.[3] Thus, it is possible for buprenorphine-trained physicians to operate out of private practices[5] and through substance abuse treatment facilities or programs. Research shows that buprenorphine may be best matched to people with mild to moderate opiate dependence, while methadone can be used for patients at all levels of opiate dependence.[6]

Although OTPs are distinguished from other treatment programs because they offer medication-assisted therapy in general and methadone in particular, it is important to note that they also provide a wide variety of nonpharmacotherapies as well.[3] For example, OTPs

In Brief

- Opioid treatment programs (OTPs) are regulated by the Substance Abuse and Mental Health Services Administration and are permitted to dispense the medications methadone and buprenorphine to treat addiction to opioids (e.g., heroin and prescription pain relievers such as oxycodone or hydrocodone).
- Of the 10,144 outpatient-only substance abuse treatment facilities in 2012, 10 percent (1,026 facilities) were OTPs.
- Compared with non-OTP facilities, OTP facilities provided fewer mental health disorder screenings (49 vs. 73 percent) and comprehensive mental health assessments (22 vs. 52 percent).
- Medications for psychiatric disorders were used by a smaller proportion of OTPs than non-OTPs (21 vs. 34 percent).
- OTPs had more than quadruple the percentages of testing services compared to non-OTPs for hepatitis C (61 vs. 13 percent) and hepatitis B (55 vs. 12 percent), and more than triple the percentage for HIV testing (59 vs. 16 percent).

that offer primarily maintenance treatment combine pharmacotherapy with a full program of assessment, psychosocial intervention, and support services; this approach has been shown to have the greatest likelihood of long-term success.[3] OTPs that offer detoxification treatment may combine pharmacotherapy with some counseling or other assistance to stabilize patients by withdrawing them in a controlled manner.[3]

The National Survey of Substance Abuse Treatment Services (N-SSATS), an annual, national survey of all known substance abuse treatment facilities, both public and private, can be used to examine the services and therapeutic approaches commonly offered in treatment. Specifically, surveyed facilities were asked whether they operated an OTP and whether they provided specific medication-based services, clinical or therapeutic approaches,[6] counseling services, and the payments accepted.

The purpose of this report is to examine the similarities and differences in the types and range of services offered among outpatient-only facilities that operated OTPs and those that did not operate OTPs (hereafter referred to as "non-OTP facilities"). Outpatient-only facilities were selected because they account for the majority of treatment modalities overall and because outpatient-only treatment was provided by 88 percent of OTP facilities in 2012. OTPs include facilities in which all clients were in primary maintenance treatment programs, detoxification-only programs, or facilities in which some clients were in a maintenance program and other clients received other forms of substance abuse treatment. These additional clients may or may not be opioid abusers.

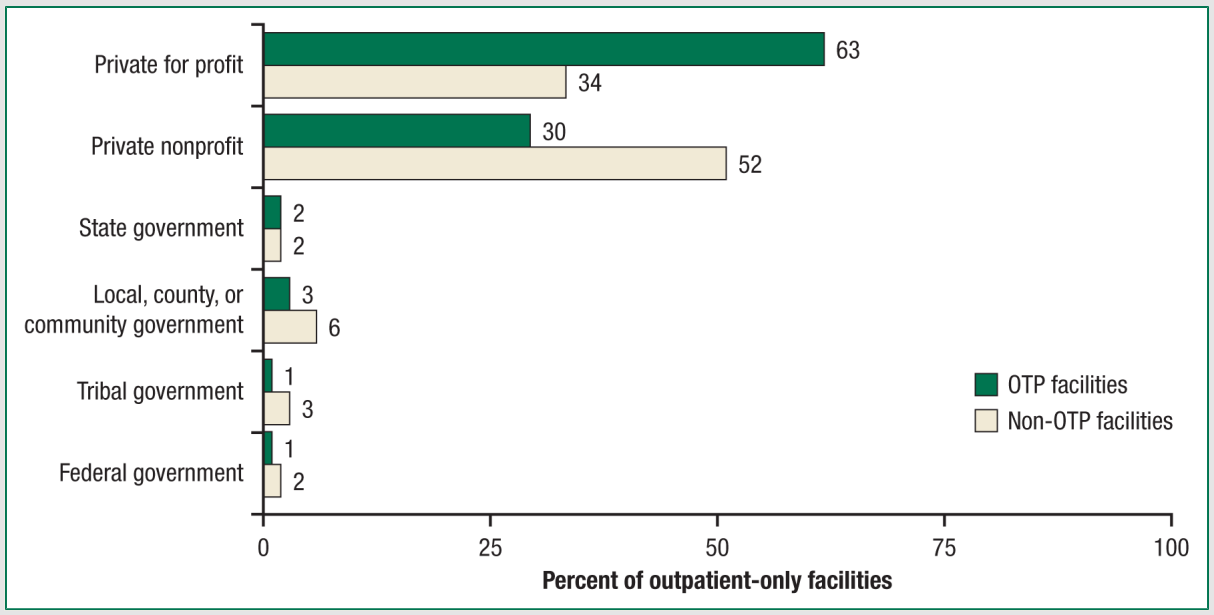
Note that N-SSATS is a census of all treatment facilities in the United States. Because N-SSATS involves actual counts rather than estimates, statistical significance and confidence intervals are not applicable. The differences mentioned in the text of this report have Cohen's h effect size ≥ 0.20, indicating that they are considered to be meaningful.

OVERVIEW

Of the 10,144 outpatient-only substance abuse treatment facilities that responded to the survey[7] in 2012, 10 percent (1,026 facilities) were OTPs. Of outpatient-only OTPs, 64 percent offered both detoxification and maintenance services, 35 percent were maintenance-only programs, and 1 percent were detoxification-only programs.

In terms of facility operation, a larger proportion of OTPs than non-OTPs were operated by a private for-profit organization (63 vs. 34 percent), while a lower proportion of OTPs than non-OTPs were operated by a private nonprofit organization (30 vs. 52 percent) (Figure 1).

Figure 1. Outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status and ownership: 2012

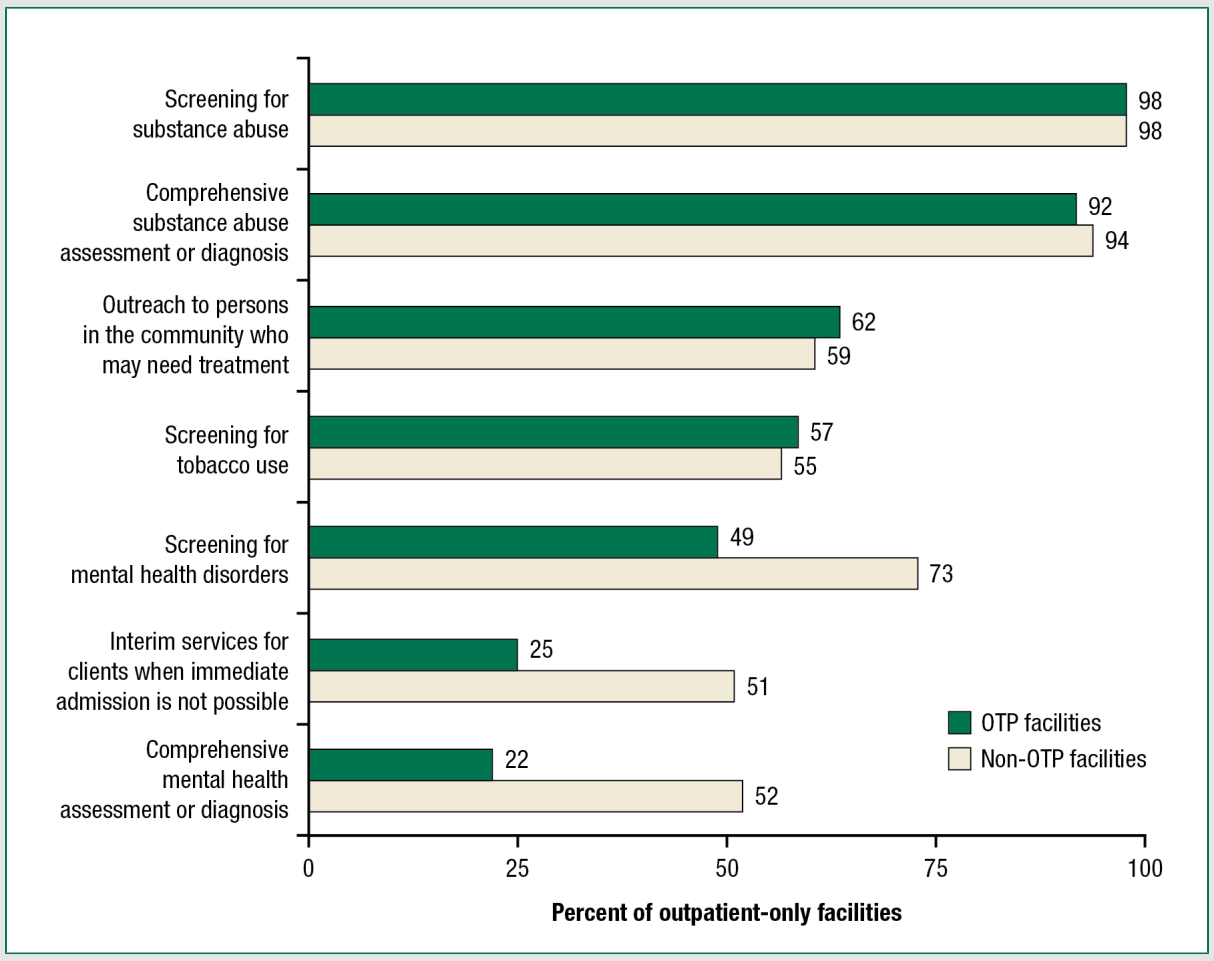


Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

PRE-TREATMENT AND ASSESSMENT SERVICES

The assessment and pre-treatment services most commonly provided by all outpatient-only facilities were screenings for substance abuse (98 percent each of OTP and non-OTP facilities) and comprehensive substance abuse assessments or diagnoses (92 percent of OTP facilities and 94 percent of non-OTP facilities) (Figure 2). Compared with non-OTP facilities, OTP facilities provided fewer mental health disorder screenings (49 vs. 73 percent), comprehensive mental health assessments or diagnoses (22 vs. 52 percent), and interim services for clients when immediate admission was not possible (25 vs. 51 percent). About 6 in 10 outpatient-only facilities provided outreach to persons in the community who may need treatment, regardless of whether they were an OTP or not (62 percent of OTPs and 59 percent of non-OTPs).

Figure 2. Pre-treatment and assessment services provided by outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012



Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

PHARMACOTHERAPIES AND DETOXIFICATION SERVICES

Buprenorphine is available in sublingual tablets or film containing either buprenorphine alone (sometimes called monotherapy tablets and marketed under the name Subutex® or as a generic drug) or combined with naloxone (called combination therapy tablets with the trade name Suboxone®).[3,8] OTP facilities provided both Suboxone® and Subutex® at higher rates than non-OTP facilities (46 vs. 13 percent and 23 vs. 7 percent, respectively) (Table 1).

Table 1. Selected pharmacotherapies provided by outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012

Pharmacotherapy	OTP facilities (percent)	Non-OTP facilities (percent)
Buprenorphine (with naloxone; Suboxone®)	46	13
Buprenorphine (Subutex® or generic)	23	7
Medications for psychiatric disorders	21	34
Antabuse®	13	15
Naltrexone	12	15
Nicotine replacement	12	14
Campral®	10	16
Vivitrol®	10	8

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

Other pharmacotherapies used for opioid, alcohol, and other substance abuse treatment were offered in similar proportions by OTP and non-OTP facilities, including Antabuse®, naltrexone, Campral®, Vivitrol®, and nicotine replacement. Medications for psychiatric disorders were used by a smaller proportion of OTP facilities than non-OTP facilities (21 vs. 34 percent).

Compared with non-OTP facilities, OTPs had a higher proportion of offering detoxification services (68 vs. 6 percent; data not shown). Of the facilities that provided detoxification services, 99 percent of OTP facilities offered opiate detoxification, compared with 86 percent of non-OTP facilities. Similar proportions of OTP and non-OTP facilities offered detoxification services for alcohol, benzodiazepines, cocaine, methamphetamines, or other substances (ranging from 3 to 6 percent). Of the OTP facilities, nearly two-thirds (64 percent) provided both maintenance and detoxification services, whereas over one-third (35 percent) provided maintenance services only.

TRANSITIONAL SERVICES

Although most facilities provided discharge planning, this service was provided by a higher proportion of OTPs than non-OTPs (98 vs. 93 percent). Aftercare/continuing care services were provided by 79 percent of OTPs and 86 percent of non-OTPs (data not shown).

THERAPEUTIC APPROACHES

N-SSATS asks facilities to report the frequency with which specific, widely recognized evidence-based clinical or therapeutic approaches were used during treatment.[9,10] Although almost all facilities—both OTP and non-OTP—provided substance abuse counseling, a higher proportion of OTP than non-OTP facilities reported using this approach always or often (98 vs. 92 percent) (Table 2). The majority of OTPs and non-OTPs also used relapse prevention (86 and 82 percent, respectively) always or often as a form of therapy. Smaller proportions of OTP facilities than non-OTP facilities reported using the following therapeutic approaches always or often: cognitive behavioral therapy (53 vs. 73 percent), 12-step facilitation (26 vs. 42 percent), anger management (19 vs. 36 percent), and trauma-related counseling (15 vs. 26 percent).

Table 2. Clinical or therapeutic approaches used "always or often" in outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012

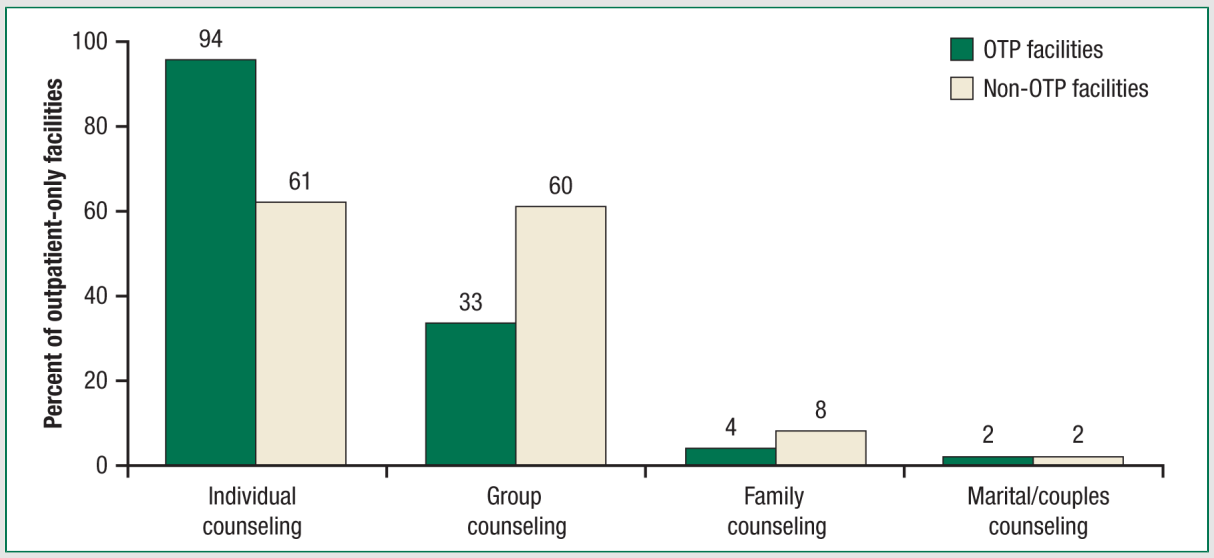
Clinical or therapeutic approach	OTP facilities (percent)	Non-OTP facilities (percent)
Substance abuse counseling	98	92
Relapse prevention	86	82
Motivational interviewing	57	63
Cognitive-behavioral therapy	53	73
Brief intervention	36	34
Contingency management/motivational incentives	30	23
12-step facilitation	26	42
Anger management	19	36
Trauma-related counseling	15	26
Matrix model	12	19
Rational emotive behavioral therapy	12	17
Community reinforcement plus vouchers	3	3

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

TYPES OF COUNSELING OFFERED

A larger proportion of OTPs than non-OTPs (94 vs. 61 percent) provided individual counseling for more than three-quarters of their clients (Figure 3). A smaller percentage of OTPs than non-OTPs provided group counseling for more than three-quarters of their clients (33 vs. 60 percent). Similar proportions provided family counseling (4 percent and 8 percent, respectively) and marital counseling (2 percent each) for more than three-quarters of their clients.

Figure 3. Types of counseling received by more than three-quarters of clients in outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012

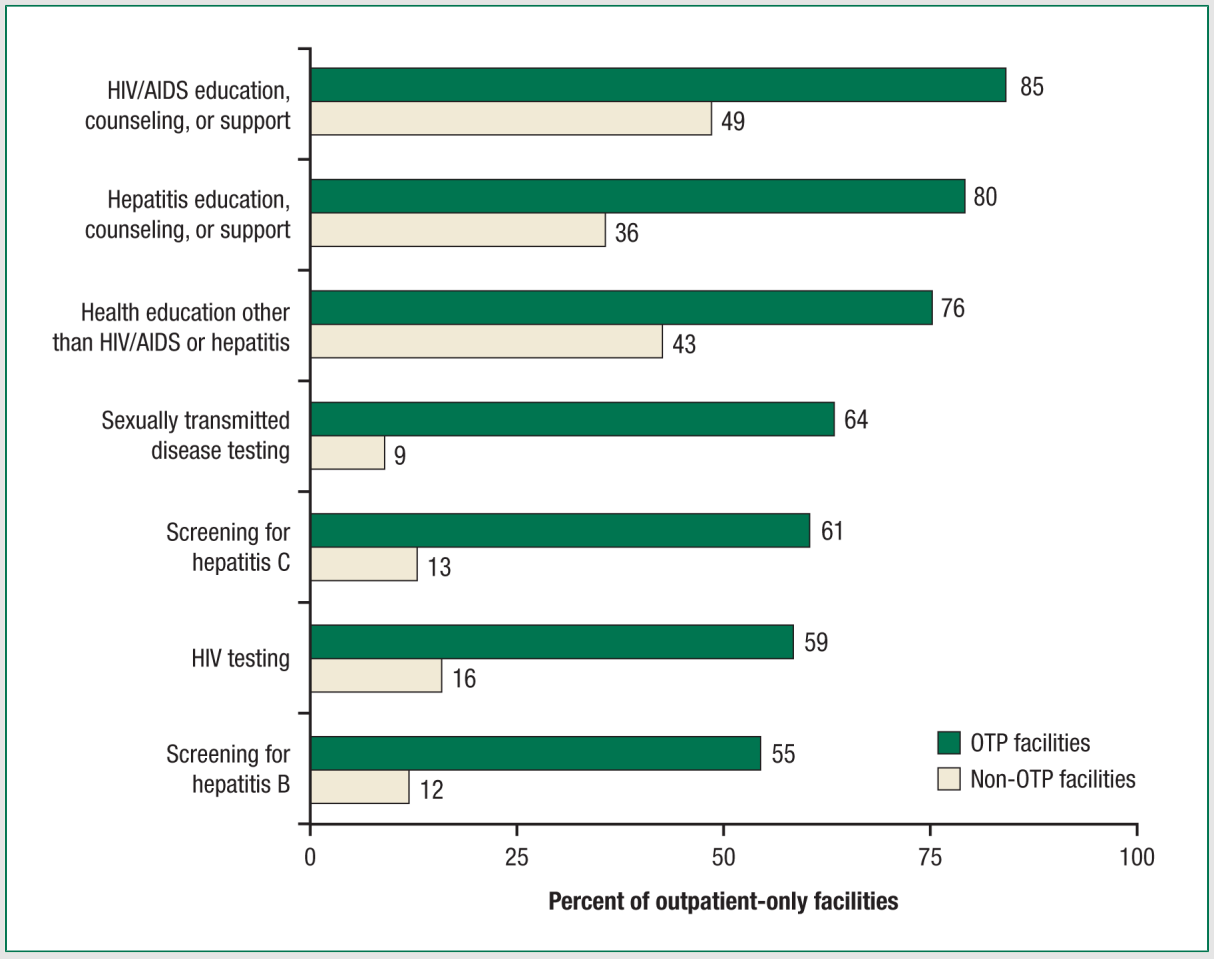


Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

TYPES OF COMMUNICABLE DISEASE-RELATED SERVICES

In general, OTPs provided more services that targeted preventing and identifying communicable diseases common among drug users compared to non-OTPs. With regard to educational services, compared to non-OTPs, a larger proportion of OTPs provided HIV/AIDS education, counseling, and support (85 vs. 49 percent); hepatitis education, counseling, and support (80 vs. 36 percent); and health education about topics/conditions other than HIV/AIDS or hepatitis (76 vs. 43 percent) (Figure 4). OTPs reported more than quadruple the percentages of testing services compared to non-OTPs for hepatitis C (61 vs. 13 percent) and hepatitis B (55 vs. 12 percent), and more than triple the percentage for HIV testing (59 vs. 16 percent).

Figure 4. Types of communicable disease-related services provided by outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012

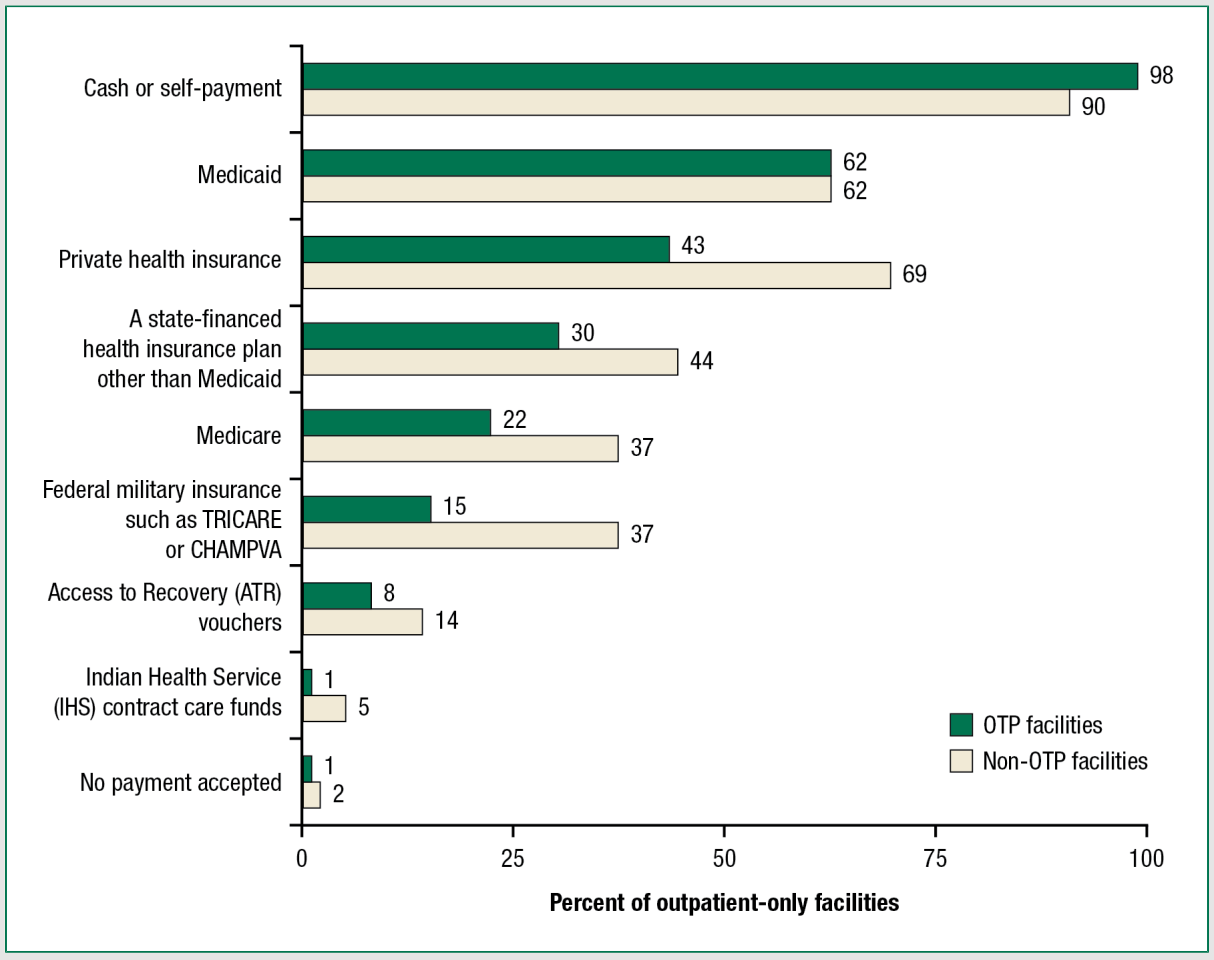


Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

TYPES OF PAYMENTS ACCEPTED

A larger percentage of OTP facilities than non-OTP facilities accepted cash or self-payments (98 vs. 90 percent, respectively) (Figure 5). Conversely, smaller proportions of OTP facilities than non-OTP facilities accepted private health insurance (43 vs. 69 percent), state-financed health insurance plans other than Medicaid (30 vs. 44 percent), Medicare (22 vs. 37 percent), and federal military insurance (e.g., TRICARE OR CHAMPVA; 15 vs. 37 percent). The majority of outpatient-only facilities accepted Medicaid, regardless of OTP status (62 percent each for both OTPs and non-OTPs).

Figure 5. Selected payments or insurance accepted by outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012



Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

DISCUSSION

Findings from this report indicate that both OTP and non-OTP facilities used a range of medical and therapeutic approaches in the treatment of their substance abuse clients. While services that directly support recovery from opioid addiction were found more frequently in OTP facilities, some services that support additional needs were more commonly found in non-OTP facilities (Table 3). Specifically, a larger proportion of OTP than non-OTP facilities offered opiate detoxification and discharge planning. Although screenings for mental health disorders, mental health assessments, and medications for psychiatric disorders were provided by a smaller proportion of OTP than non-OTP facilities, OTPs provided more educational and testing services for communicable diseases compared to non-OTPs.

Table 3. Summary of differences found between outpatient-only substance abuse treatment facilities, by opioid treatment program (OTP) status: 2012

Substance abuse treatment facilities that were opioid treatment programs (OTPs) were MORE likely than non-OTP facilities to be or to report being:

- Operated by a private for-profit organization
- Offering buprenorphine
- Offering detoxification services
- Offering discharge planning
- Often or always offering substance abuse counseling
- Offering individual counseling to more than three-quarters of clients
- Offering HIV/AIDS education, counseling, or support; hepatitis education, counseling or support; and health education other than HIV/AIDS or hepatitis
- Offering testing services for HIV/AIDS, hepatitis B, and hepatitis C
- Accepting cash or self-payments

Substance abuse treatment facilities that were opioid treatment programs (OTPs) were LESS likely than non-OTP facilities to be or to report being:

- Operated by a private nonprofit organization
- Operated by a government agency
- Providing mental health disorder screenings
- Providing comprehensive mental health assessments
- Providing interim services
- Providing medications for psychiatric disorders
- Often or always offering cognitive-behavioral therapy
- Often or always offering 12-step facilitation
- Often or always offering anger management
- Often or always offering trauma-related counseling
- Offering group counseling to more than three-quarters of clients
- Accepting private health insurance, Medicare, state-financed health insurance, federal military insurance, and Indian Health Service (IHS) contract care funds

Source: SAMHSA National Survey of Substance Abuse Treatment Services (N-SSATS), 2012.

Many evidence-based therapeutic approaches were provided by OTP and non-OTP facilities. Over 90 percent of outpatient-only facilities used substance abuse counseling, and the majority of both types of facility also used relapse prevention. Over half of OTP facilities used motivational interviewing and cognitive behavioral therapy always or often, over a third used brief intervention, and over a quarter used contingency management and 12-step facilitation always or often. The use of varied evidence-based approaches demonstrates positive efforts on the parts of these facilities to consider the specific needs of different client populations. Additional information on evidence-based treatment approaches is available at the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices (NREPP) (http://www.nrepp.samhsa.gov/).

Finally, the findings in this report showed several differences between OTPs and non-OTPs with regard to the type of payments accepted. Treatment professionals or health care providers making referrals to people in need of opioid treatment can access SAMHSA's Behavioral Health Treatment Services Locator http://findtreatment.samhsa.gov/ to identify nearby opioid treatment programs that will accept the client's anticipated method of payment.

END NOTES

1. Center for Behavioral Health Statistics and Quality. (2013). *Results from the 2012 National Survey on Drug Use and Health: Summary of national findings* (HHS Publication No. SMA 13–4795, NSDUH Series H–46). Rockville, MD: Substance Abuse and Mental Health Services Administration.
2. Mental Health and Drug and Alcohol Office, New South Wales Department of Health. (2008). *NSW drug and alcohol withdrawal clinical practice guidelines*. Retrieved from http://www0.health.nsw.gov.au/policies/gl/2008/pdf/gl2008_011.pdf
3. Center for Substance Abuse Treatment. (2005). *Medication-assisted treatment for opioid addiction in opioid treatment programs* (HHS Publication No. SMA 12–4214, Treatment Improvement Protocol [TIP] Series, No. 43). Rockville, MD: Substance Abuse and Mental Health Services Administration.
4. Any OTP patient may receive a single take-home dose for a day when the OTP is closed for business, including Sundays and state and federal holidays. Beyond this, decisions on dispensing take-home medication are determined by the medical director in accordance with criteria specified in federal regulations (42 CFR, Part 8 §12(i)).
5. This report does not include data from private physicians who are not affiliated with a substance abuse treatment program or facility.
6. Whelan, P. J., & Remski, K. (2012). Buprenorphine vs methadone treatment: A review of evidence in both developed and developing worlds. *Journal of Neurosciences in Rural Practice, 3*(1), 45–50. doi: 10.4103/0976-3147.91934
7. The overall response rate among facilities responding to the 2012 N-SSATS was 93.1 percent.
8. The combination tablet was developed because of problems with injection abuse of buprenorphine reported outside the United States; in the United States injection of buprenorphine is not permitted for treatment. Injected alone, buprenorphine precipitates withdrawal symptoms in most patients who are opioid addicted, and the addition of naloxone increases this likelihood.
9. Brief definitions of the reported clinical and therapeutic approaches are summarized in *The N-SSATS Report: Clinical or Therapeutic Approaches Used by Substance Abuse Treatment Facilities*, which may be accessed at: http://www.thepottersclinic.com/uploads/N-SSATS_Report.pdf. Additional information on the therapeutic approaches and counseling types described in this report may be found at the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-Based Programs and Practices (NREPP) at http://www.nrepp.samhsa.gov/, and SAMHSA's Treatment Improvement Protocols (TIPS) at http://store.samhsa.gov/list/series?name=TIP-Series-Treatment-Improvement-Protocols-TIPS-.
10. The clinical or therapeutic approaches assessed in N-SSATS were selected based on their representation of widely recognized evidence-based practices in substance abuse treatment. The N-SSATS questionnaire does not include detailed questions about the ways in which the therapeutic approaches are implemented, but is intended to provide a general indication of their adoption by substance abuse treatment providers.

SUGGESTED CITATION

Strashny, A. *Services Offered by Outpatient-Only Opioid Treatment Programs: 2012.* The CBHSQ Report: October 23, 2014. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

SUMMARY

Background: Trend data between 2002 and 2012 show that the number of persons meeting the criteria for heroin dependence or abuse in 2012 was more than double that in 2002 (467,000 vs. 214,000), and the number of persons with pain reliever dependence or abuse rose from 1.4 million to 2.1 million between 2004 and 2012. Methadone, in use since 1964 for opioid dependence, may be dispensed only in federally approved opioid treatment programs (OTPs). Buprenorphine may be prescribed by physicians who obtain specialized training. Although OTPs are distinguished from other treatment programs because they offer medication-assisted therapy in general and methadone in particular, it is important to note that they also provide a wide variety of nonpharmacotherapies as well. **Methods:** The purpose of this report is to examine the similarities and differences in the types and range of services offered among outpatient-only facilities that operated OTPs and those that did not operate OTPs (non-OTP facilities). Outpatient-only facilities were selected because they account for the majority of treatment modalities overall and because outpatient-only treatment was provided by 88 percent of OTP facilities in 2012. **Results:** Of the 10,144 outpatient-only substance abuse treatment facilities in 2012, 10 percent (1,026 facilities) were OTPs. Compared with non-OTP facilities, OTP facilities provided fewer mental health disorder screenings (49 vs. 73%) and comprehensive mental health assessments (22 vs. 52%). Medications for psychiatric disorders were used by a smaller proportion of OTPs than non-OTPs (21 vs. 34%). OTPs had more than quadruple the percentages of testing services compared to non-OTPs for hepatitis C (61 vs. 13%) and hepatitis B (55 vs. 12%), and more than triple the percentage for HIV testing (59 vs. 16%). **Conclusion:** A larger proportion of OTP than non-OTP facilities offered opiate detoxification and discharge planning. Although screenings for mental health disorders, mental health assessments, and medications for psychiatric disorders were provided by a smaller proportion of OTP than non-OTP facilities, OTPs provided more educational and testing services for communicable diseases compared to non-OTPs. Over 90% of outpatient-only facilities used substance abuse counseling, and the majority of both types of facility also used relapse prevention. Over half of OTP facilities used motivational interviewing and cognitive behavioral therapy always or often, over a third used brief intervention, and over a quarter used contingency management and 12-step facilitation always or often.

Key Words: opioid treatment programs, OTPs, National Survey of Substance Abuse Treatment Services, NSSATS

AUTHOR INFORMATION

cbhsqrequest@samhsa.hhs.gov

KEYWORDS

Short Report, Substance Abuse Facility Data, Researchers

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

The National Survey of Substance Abuse Treatment Services (N-SSATS) is an annual survey designed to collect information from facilities in the United States, both public and private, that provide substance abuse treatment. N-SSATS provides a mechanism for quantifying the dynamic character and composition of the United States substance abuse treatment delivery system. The objectives of N-SSATS are to collect multipurpose data that can be used to assist SAMHSA and State and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Behavioral Health Services (I-BHS), to analyze general treatment services trends, and to generate Substance Abuse Treatment facility Locator [http://findtreatment.samhsa.gov/].

N-SSATS is one component of the Behavioral Health Services Information System (BHSIS), maintained by the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA. N-SSATS collects three types of information from facilities (1) characteristics of individual facilities such as services offered and types of treatment provided, primary focus of the facility, and payment options; (2) client count information such as counts of clients served by service type and number of beds designated for treatment; and (3) general information such as licensure, certification, or accreditation and facility website availability. In 2012, N-SSATS collected information from 14,311 facilities from all 50 states, the District of Columbia, Puerto Rico, the Federated States of Micronesia, Guam, Palau, and the Virgin Islands. **Information and data for this report are based on data reported to N-SSATS for the survey reference date March 30, 2012.**

The N-SSATS Report is prepared by the Center for Behavioral Health Statistics and Quality (CBHSQ), SAMHSA, Synectics for Management Decisions, INC., Arlington, VA; and by RTI International in Research Triangle Park, NC.

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